STATE
DENTAL SERVICES CLAIM FORM

BlueCross BlueShield of South Carolina
An Independent Licensee of the Blue Cross and Blue Shield Association

☐ DENTIST'S PRE-TREATMENT ESTIMATE
☐ DENTIST'S STATEMENT OF ACTUAL SERVICES

☐ **Blue Shield – Oral Surgery** ☐ **Dental Insurance**
☐ **Major Medical** ☐ **FEP Dental Insurance**

PART I – TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME First Initial Last

2. Relationship to Employee: Self | Spouse | Child | Other

3. Sex: M | F

4. Patient Birthdate: Mo. | Day | Year

5. If full-time student: School City

6. Employee/Subscriber Name First Middle Last

7. Employee Social Security No./Contract No.

8. Employee/Subscriber Mailing Address

City State Zip

9. Employer (Company) Name and Address

10. I hereby authorize release of any information relative to this claim to the insurer and direct that benefits be made payable to: ☐ Dentist ☐ Myself

Date Employee or Spouse Signature

11. Do you or your spouse have any other dental insurance? ☐ Yes ☐ No
If yes, please answer the following questions:
Policyholder's Name:
SSN or ID No.:
Name and Address of Policyholder's Employer:

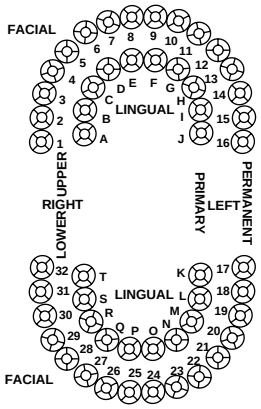
PART II – TO BE COMPLETED BY ATTENDING DENTIST

	No	Yes	If YES, enter brief description and dates
12. Is treatment result of occupational illness or injury?			
13. Is treatment result of auto accident?			
14. Other accident?			
15. Are any services covered by another plan or Medicare B?			
16. If prosthesis, is this initial placement?			(If NO, Reason for Replacement) — 17. Date of Prior Placement
18. Is treatment for orthodontics?			If services already commenced: Enter Mos. Treatment Remaining — Date of case diagnosis

Date Appliances Placed

19. REMARKS FOR UNUSUAL SERVICES

X-rays submitted
☐ Yes ☐ No



Ir. Indicate Missing Teeth With An "X"

20. EXAMINATION AND TREATMENT PLAN. LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32.

A Tooth No. or Letter	B Surface	C Date of Service	D Place of Service *	E Procedure Code	E Modifiers	Description of Services (Including X-rays, prophylaxis, materials used, etc.)	F Diagnosis Code	G Charges	H (For Administrative Use Only) Type Service	Days Units	MP SPI	AC Code	Disp	RB LF

21. Signature of Dentist
(I certify that the statements on the reverse apply to this bill and are made a part hereof.)

Signed Date

22. Your Patient's Account No.

26. Accept Assignment *(See back)*
Yes ☐☐ No

27. Your Social Security No.

28. Your Employer I.D. No.

23. Total Charge

24. Amount Paid

25. Balance Due

29. Physician's or Supplier's Name, Address, Zip Code and Telephone No.

I.D. No.

10/03

*** PLACE OF SERVICE CODES**
1 – Inpatient Hospital
2 – Outpatient Hospital
3 – Doctor's Office
4 – Patient's Home
5 – Day Care Facility
6 – Night Care Facility
7 – Nursing Home
8 – Skilled Nursing Facility
9 – Ambulance
0 – Other Locations
A – Independent Laboratory
B – Other Medical/Surgical Facilities

CLAIM FORM INSTRUCTIONS

PLEASE BE SURE TO CHECK THE APPROPRIATE BLOCK ON THE FRONT OF THE CLAIM FORM (I.E. BLUE SHIELD – ORAL SURGERY, DENTAL INSURANCE, MAJOR MEDICAL, OR FEP DENTAL INSURANCE).

ITEMS 1-11 – MEMBER INFORMATION

The patient provides information on Items 1-11 in order for the coverage to be identified. (Note: *All* items must be completed before we can process your claim.)

ITEMS 12-29 – DENTIST INFORMATION

Please complete Items 12-29.

SIGNATURE ITEM 21:
I certify that I personally performed the described services or they were performed by my employee under my immediate personal supervision.

ASSIGNMENT ITEM 26:
When I mark Item 26 "Yes" and properly complete this claim form, I understand that any covered benefit payment will be made directly to me.

When I mark Item 26 "No" or fail to mark it either "Yes" or "No," I further understand that any covered benefit payment will be made directly to the insured subscriber.

ITEM 27:
Complete this item if filing under a corporation name.

A pre-determination of benefits can be made only when such charges for the course of treatment to be performed will exceed $100.00. For such cases, please complete all items on the claim form except Item No. 20C (date(s) of service) indicating the treatment plan and the estimated charges and mail to the address below. A pre-determination form will be returned to you indicating the allowable amount. This amount is always subject to the deductible and coinsurance provisions of the contract. Upon completion of the services indicated on the treatment plan, enter the date(s) the services were performed and submit the pre-determination form for payment of benefits. NOTE: There is no preauthorization of benefits for the FEP Dental Insurance program.

MAIL ALL DENTAL CLAIM FORMS TO:

BlueCross BlueShield of South Carolina
State Dental Claims Department
P.O. Box 100300
Columbia, South Carolina 29202-3300